

☐ Within the past 5 years (2 to 5 years ago)

 \Box 5 or more years ago

 \square Don't know/not sure \square Never



Contraction of the contract of											10		
Client ID Number:							Today's Date:						
Please complete and sign				a for l	ifa (SEL) a	and Health Care Co	nnaction (H		ay 3 Date	•			
• SFL offers breast, prosta					•		mnection (n	cc).					
HCC is a referral service to			_			_							
For additional information					•	d tower cost.							
Tor additional information	about 51 E and 11cc,	piec											
			TI	HIS	IS NO	T INSURANC	CE						
			4			formation	(1166)2						
How did you hear about t	ne <i>Screening for Lif</i>	e Pro	gram (:	ofL) al	na/or <i>Hea</i>	iith Care Connectio	on (HCC)?						
☐ Newspaper ☐ TV ☐ In	iternet 🗌 Radio 🗆	Bill	board	☐ Dire	ect mail to	residence 🗆 Cli	inic, health (center	, doctor's	office	□Hosp	ital	
\square Other, please specify $_$													_
Last Name:													
Maiden Name:													
Home Address:													
City:													_
Mailing Address (if differen													_
Daytime Phone:	Other	Phor	ne:			Email Addres	ss:						_
Primary Language: Engl	ish \square Spanish \square C	ther	·										
1. What is the highest lev	vel of education you	hav	e compl	eted?									
\square Less than high school	ol 🗆 Some hig	gh sc	hool		High sch	ool graduate	\square More th	an hig	gh school				
Hausahald mambara, Tall		a:l.,	المسمطط	tional	househo	ld mambara	. comoveto c	haat a	fnanar				
Household members: Tell How many people are in y							a separate s	neet o	r paper.				
now many people are my	your nousenotu		1	(''''	T Turning yo	1							
Last Name	First Name	М	How is this	Date of	Sex M=Male	Social Security	,	Race*	Hispanic or Latin	Served in	U.S. citizen?	Legal alien?	Is the person
			person	Birth	F=Female				origin? Y=Yes	Armed Forces?	Y=Yes	Y=Yes N=No	insured?
			related to						N=No	Y=Yes	N=No	IN=INO	Y=Yes N=No
		╄	you?							N=No			
			Self										
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		$oxed{oxed}$											
*Races: White (W); Black/	Nerican Amarican (D.	΄ΛΛ).	Asian (1). Not	ive Herre	::an (NII) ar athar	Dosific Islan	dar (Di). Amorio	مم امطند	· (AI) a		
	N); unknown (u); 2 o), Amenic	an muia	III (AI) UI		
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					iliant E	liaihilit.							
				•	Luent E	ligibility							
2. What kind of healthcar	re coverage do you	nave	?			7. What is the	main reaso	n you	are witho	ut heal	thcare c	overag	e?
(check all that apply)						☐ Lost job o	r changed e	mploy	ers				
☐ Medicare (please circ		low)				-	\square Spouse or parent lost job or changed employers						
	SLMB QMB						Became divorced or separated						
☐ Medicaid							Became ineligible because of age or leaving school						
☐ Tricare, VA benefits	40 PPO +)						Employer doesn't offer or stopped offering coverage						
☐ Private insurance (H/							Cut back to part-time or became temporary employee						
☐ Other (Please specify☐ None (Skip to question							Benefits from former employer ran out (COBRA)						
		nav f	or.				□ Couldn't afford to pay premium□ Insurance company refused coverage						
3. This year, does your healthcare coverage pay for:							Lost Medicaid or Medical Assistance Eligibility						
□ Pap smears□ Mammograms□ Colorectal exams□ Prostate screenings							Spouse or parent paid						
Lung cancer screening						-	Other (Please specify.)						
4. Have you met your ded	_					☐ Don't kno							
☐ Yes (Specify amount	of deductible.) \$					8. What is you	ır income be	fore d	eduction	s (gross	income	<u>.</u>)?	
\square No (Specify amount o	of deductible.) \$					☐ Weekly ☐	Biweekly	Mor	nthly 🗆 A	nnually			
\square Does not apply						9. Are you (ple	ease check a	ıll tha	t apply):				
5. Have there been any cl	nanges in your heal	thca	re cover	age in	the	\square Employed	_			Stude			
past 6 months?						Receiving	=			Retire			
☐ Yes ☐ No						Receiving		npens			ing child		
. ,						☐ Unable to					ing une		nent
6. How long has it been since you had healthcare coverage?							□ Receiving SSI/SSD□ Homemaker□ Receiving pension						
☐ Within the past 6 mo		_	1			☐ Homemak☐ Out of wo		n one :		_ kecei\	ıng pen	sion	
☐ Within the past year☐ Within the past 2 yea						□ Out of wo							
- within the past 2 year	(I to 2 years ago,					_ Jul OI WO	was ulall	one ye	۵.				

 \square Receiving Temporary Assistance for Needy Families (TANF)

Access and Use

10. Was there a ti to see a docto reasons? Plea Cost Inc Language b 11. Do you have a (A primary car checkup and s Yes No City 14. In the past 6 r Yes Date No If yes, please check	12. If you are sick and need medical advice, where do you go? Doctor's office Clinic or health center Hospital Outpatient department Hospital emergency department Urgent care center Some other kind of place Don't know/not sure 13. What type of assistance, if any, do you need in making or keeping medical appointments? Childcare/eldercare Transportation Language None Other, please describe Other, please describe Information 15. Have you or any member of your immediate family had cancer? (Immediate family includes parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, and nephews.) Yes No (Skip to question 16)							
	Name	Age at Diagnosis	Siblings/ Children	Age at Diagnosis	Mother's Side	Age at Diagnosis	Father's Side	Age at Diagnosis
For Example: Colorectal Cancer	You	36 yrs.	Brother	36 yrs.	Aunt Cousin	58 yrs. 44 yrs.	Grandmother	65 yrs.
Breast Cancer								
Cervical Cancer								
Ovarian Cancer								
Colorectal Cancer								
Prostate Cancer								
Other 16. Currently, do								
tobacco produ	24. Has a doctor, nurse or other healthcare professional ever told you that you have high blood pressure? Yes Yes, but only when I was pregnant No, but told I was pre-hypertensive or borderline high No Don't know/not sure 25. Has a doctor, nurse or other healthcare professional ever told you that your blood cholesterol is high? Yes No, but told I was borderline high No Don't know/not sure 26. Women only: Are you pregnant? Yes No 27. Women only: Do you plan to become pregnant in the next year? Yes No 28. Women only: Do you still have your cervix? Yes No 28a. If no, was it removed due to cervical cancer or pre-cervical cancer? Yes No 29. Do you have a disability? Yes No							
□					Release Info	rmation		
	nt for you to acce	ess the state info	ormation system t	to determine m	ny eligibility for m se of survey, stud			
Client Signature:						Date		
Medicaid Appli ☐ Medicaid pe ☐ Enrolled full	ry Date: cation Status nding	nrolled limited M	edicaid only	□ No	ot completed beca ot completed beca ot completed beca	use over inco	me for Medicaid	

